DoD Medical Examination Review Board
8034 Edgerton Drive, Suite 132
USAF Academy, Colorado 80840-2200

ASTHMA, REACTIVE AIRWAY, EXERCISE-INDUCED BRONCHOSPASM QUESTIONNAIRE

NAME: _____ SOCIAL SECURITY NUMBER: _____-_____-_____

Please complete all of the questions below regarding history of asthma or breathing related conditions and return this form to DoDMERB at the above address: If more space is needed, please use back of form and identify each issue by question number.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397
PRINCIPAL PURPOSE: To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corp (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).
ROUTINE USES: This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applicants to their Academies.
DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

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1) Which of the following have you ever been diagnosed with (Circle all that apply):

asthma **reactive airway disease** **exercise induced bronchospasm** **wheezing or shortness of breath**
Other (Please describe) **_____** **none of the these**?

If diagnosed with any of the above, please answer questions a through e below:

a) Age of onset: _____

b) Have you ever been treated in an emergency room or admitted to a hospital for breathing difficulties? (circle) YES NO If yes, please explain in detail:

_____
_____
_____

c) When did you last experience symptoms (wheezing, shortness of breath, chest pain, etc.) or an attack: (Date) _____

d) When did you last use medications such as inhalers, nebulizer, pills: (Date)_____

e) Please list any/all medications used to treat the above condition with approximate dates of use and frequency of use when taken: (e.g., daily, weekly, seasonal, prior to athletic/recreational activities, or as needed):

Medication (e.g. Albuterol, Singulair): Dates used (e.g. 6/2003-5/2009): Frequency:

_____
_____
_____
_____

2) Certification: By signing below, I hereby certify that the above information is true and accurate to the best of my knowledge.

_____ _____
Applicant's Signature Date